525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464

BI-STATE PRIMARY CARE ASSOCIATION
SERVING VERMONT & NEW HAMPSHIRE

61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

Written Testimony on substitution amendment to H.766 to House Health Care Committee

Mary Kate Mohlman, Director, Vermont Public Policy
Bi-State Primary Care Association
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Chair Houghton and Members of the Committee:

Thank you for the opportunity to provide written testimony on H. 766, an act relating to prior authorization and step therapy requirements, health insurance claims, provider contracts, and collection of cost sharing amounts. I am writing on behalf of Bi-State Primary Care Association and our members.

Bi-State Primary Care Association is a nonprofit organization established in 1986 to advance access to comprehensive primary care and preventive services for anyone regardless of insurance status or ability to pay. Today, Bi-State represents 26 member organizations across both Vermont and New Hampshire. Our members include Federally Qualified Health Centers (FQHCs), Vermont Free and Referral Clinics, and Planned Parenthood of Northern New England.

Bi-State strongly supports the updated version of H.766, and we very much appreciate the time and effort put in by this committee to addressing the administrative burden that is crippling our providers and ultimately affecting the quality of care provided to Vermonters.

Administrative burden, including excessive prior authorizations and step therapy requirements, and unpredictable claims edits, is having a profound impact on our members. When providers and their billing/financial teams must consistently struggle to get their patients the procedures and medicine they need or to chase down reimbursement for care that has been provided, the burden becomes a workforce issue as staff and clinicians seek less demoralizing and frustrating work options.

While payers state that prior authorizations, step therapy, and the claims editing process are in place to save the health system money, their calculations do not factor in the increased cost to providers when they must meet these requirements. Our members have hired additional clinical and administrative staff to process the large number of prior authorizations. Doctors and advance practice providers have taken time away from patients to spend on phone calls with payers, usually ending with the provider's original request approved. Health centers have foregone reimbursement when pursuing that payment required more resources than it was worth.

By increasing alignment in claims edits and prior authorization requirements across payers, H.766 is a significant step forward to addressing many of the provider concerns and providing relief. We recognize that the state cannot regulate all payers, including those plans covered under Employee Retirement Income Security Act of 1974 (ERISA), but every step towards alignment reduces the number of different payer-specific requirements to which providers must adhere.

Again, we thank the committee for the work and time that has been put into this bill. I am available if you have further questions about the impact that this bill will have on our members.